Medicaid Information Bulletin

July 2003

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TABLE OF CONTENTS

TABLE OF CONTENTS, continued

BULLETINS BY TYPE OF SERVICE

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03 - 25 Home Health Revisions HIPAA Compliant

To comply with HIPAA regulations, the Medicaid specific "Y" codes have been converted to HCPCS alphanumeric codes. Effective October 1, 2003, claims must be submitted with standard HCPCS coding. Minor changes in policy, definition and coding structure were necessary to implement HIPAA coding definitions and time increments. The changes include:

Services are limited to one visit per day, with the exception of a skilled service (injection, dressing change, medication pre-fills, etc.) which cannot be provided by the skilled aide who provides the routine care. Minimum 15 minute increments will be allowed for the skilled service.

Time units are now 15 minutes, hourly, or daily and will be approved by review of the plan of care, evaluation of the severity of illness and intensity of service necessary.

The Long Term (capitated) monthly program will be covered with a daily fee which equates to the monthly maximum. Any non-service days must be deducted.

Chapter 6, HOME HEALTH PROCEDURE CODES have been completely rewritten to outline the changes.

Private Duty Nursing is a special program under Home Health for a limited population. A brief summary of criteria and codes have been included in Chapter 6.

Pages to update your Home Health Manual are included. ☐

03 - 26 Medical Supplies

Quantity Limitations

Exceeding quantities and limitations as stated in the Medicaid Medical Supplies Manual requires prior authorization. Sterile water, A4319, is open only to clients who are on the technology dependent waiver such as the Travis C Waiver. A few other select codes may have different limits allowed for those under a waiver. To determine if a client is on a waiver please call Medicaid Customer Service 538-6155 or 1-800-662-9651. If it is medically necessary to exceed the limits listed in the Manual – including the extra limits allowed to waivered clients, a prior authorization must be obtained.

Oximeter price changes

Beginning July 1, 2003, code E0445 RR, Oximeter, is changing the pricing structure from a monthly rental to a daily rental. One unit equals one day. For weekly authorization bill 7 units and for monthly rental bill 30 or 31 units.

Billing Modifiers

Medicaid is now using the RR and LL modifiers for rentals. The LL modifier is a capped rental, which means after 12 rental months no more rental months are allowed and the rental is capped and considered a purchase. New equipment must be placed at the beginning, during or at the time of conversion to a purchase.

The following codes have been added to the medical supplies program:

A4319, sterile water, irrigation, 1000 ml. Only open for patients under the Technology Dependent waiver. TD2 or TD4. Up to 30 liters per month.
A4536, Protective underwear, washable any size (for use with liners/shield)
A7005, Administration set with small volume non-filtered pneumatic nebulizer, non-disposable
B4034, Enteral feeding supply kit, syringe, per day
B4036, Enteral feeding supply kit; gravity fed per day
E0143 P or LL, Walker, wheeled, without seat, folding (rental per month)
K0006LL, Heavy duty wheelchair

The following codes have been replaced:

A4460, Elastic bandage is replaced with
A6430, Light compression bandage, 3-5 inch wide (elastic bandage)

A6434, Medium compression bandage, 3-5 inch wide (elastic bandage)

A6265, Tape, any type is replaced with
A4450, Tape, non-waterproof, 18 square inches
A4452, Tape, waterproof, 18 square inches

Y0377, Shoe to be attached to a brace or orthosis, and
L3224, Orthopedic footwear, female shoe, used as part of a brace
L3225, Orthopedic footwear, male shoe, used as a part of a brace

Y0422, Peripheral/midline I.V. catheter/shut for peripheral vein is replaced with
S5520, Home infusion therapy, all supplies (including catheter)necessary for a peripherally inserted central venous catheter (PICC) line insertion.

Y0423, Midline I.V. catheter, soft, including insertion, and Y0424, Central line I.V. catheter tip placed in superior vena cava are replaced with
S5521, Home infusion therapy, all supples (including catheter)necessary for a midline line insertion.

Y0425, I.V. tubing extension set for peripheral or midline I.V. catheter is replaced with
S1015, I.V. tubing extension set

Y0426, Central line IV extension set is replaced with
S1015, IV tubing extension set

Y0427, Bio-occlusal dressing, only for catheter
A6257, Transparent film 16 sq in or less.

Y0429RR, I.V. infusion pump, and Y0472RR, Pump with cartridge TPN and I.V. and Y0436, cartridge for pump is replaced with
E0791RR, parenteral infusion pump, stationary single or multi-channel

Y0430, I.V. supply/administration kit, home use, each
Z6006, I.V. set, includes tubing, needle, antiseptic, and glove

Y0431, Syringe for IV flow pump replacement is replaced with
K0552, Supplies external infusion pump, syringe, cartridges, sterile, ea

Y0434, Primary IV administration set and Y0435, Secondary IV line set are replaced with
Z6006, IV set, including tubing, needle, antiseptic, glove

Y0437, Dial-a-flow pump/tubing , regulator or supplies is replaced with
E0779, Ambulatory infusion pump, reusable, infusion more than 8 hrs and
E0780, Ambulatory infusion pump, reusable, infusion less than 8 hours.

Y0470, Artificial Nose (RMO Vent) and V0471, Artificial nose tubing are replaced with
A4483, Moisture exchanger, disposable (limited to 30 per month).

Y0472, Pump with cartridge per day and Y0436, Cartridge for pancreatic pump is replaced with
E0781, Ambulatory infusion pump (such as Maxx or microject), single or multiple channels, with administrative equipment, worn by patient.

Y0556, Extension tubes is replaced with
K0046, Foot rest extension tubes
K0048, Elevating foot rest extension tubes

Y0564, Disposable infusion pump, any brand is replaced by
A4305, Disposable Drug Delivery System, flow rate greater than 5 ml per hour
A4306, Disposable Drug Delivery System, flow rate less than 5 ml per hour.

Y0573, Shoulder retractor is replaced with
E0710, restraints, any type (body, chest, wrist, leg)

Y0661, Motorized wheelchair, pediatric, and all attachments and
Y0664, Motorized wheelchair, adult and all attachments are replaced with
E1210, Motorized wheelchair, fixed full length arms, swing away detachable leg rests and any addition attachments
E1211, Motorized wheelchair, detachable desk or full length arms, swing away detachable foot rests.
E1212, Motorized wheelchair, fixed full length arms, swing away detachable toot rests
E1213, Motorized wheelchair, detachable desk or full length arms, detachable elevating foot rest.

Y1499, Lymphedema sleeve and gauntlet is replaced by
S8424, Gradient pressure aid (sleeve), ready made
S8428, Gradient pressure aid (gauntlet), ready made

Y4021, Dispos bag w/tubing, side-kick 50 ml/100 is replaced by
A4305, Disposable drug delivery system, flow rate 50 ml and greater
A4306, Disposable drug delivery system, flow rate 50 ml or less

Y4025, Mic-key Button and Y4026, Mic-key Button tubing is replaced with
use temporarily, B9998, NOC for enteral supplies, please bill with brand name. This will be manually priced.

Y4100, Gastrostomy tube with silicone sliding ring. one is replaced with
B4086, Gastrostomy/jejunostomy tube, any type.

Y4362, Skin barrier, stoma adhesive 8x8 is replaced with
A5122, Skin Barrier, solid, 8x8

Y6002, External modification appliance for a shoe owned by patient, and Y6003, Shoe to be attached to a brace or orthosis, per shoe is replaced by

A5507, Diabetic only, modification of a shoe (includes fitting)

Y6005, Trach Ties/twill tape and Y6011, trach sponges/gauze are replaced with

S8189, Misc. trach supplies (prior authorization required)

Y6007, Non-self wheelchair, Tilt in Space is replaced with

E1161, Manual adult size wheel chair, including Tilt in Space

Y6009RR, Air Bed is replaced by

E0193RR. Powered air flotation bed, (low air loss therapy)

Y6010RR, Oximeter, pulse, not intermittent is replaced by\

E0445RR, Oximeter device for measuring blood oxygen levels non-invasively(one days rental)

Y6013, Oximeter service with reading for physician one monthly is replaced by

E0445RR, Oximeter device or measuring blood oxygen levels non-invasively (one days rental)

Y6014, Vaseline gauze, per roll is replaced with

A6222, Gauze, impregnated with other than water, normal saline, or hydrogel, 16 sq in or less without adhesive border, ea,

A6223, Gauze, impregnated with other than water, normal saline, or hydrogel, more than 16 but less than 48 sq. inches.

A6224, Gauze, impregnated with other than water, normal saline or hydrogel, greater than 48 sq. inches.

Y6015RR, Oximeter pulse, per week is replace by

E0445RR, Oximeter device for measuring blood oxygen levels non-invasively (one days rental)

Y6016, Chaston Gauze, conforming is replaced with

A6422, conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 3 inches and less than 5 inches per roll (at least 3 yards, unstretched)

A6424 conforming bandage, non-elastic, knitted/woven, non-sterile, width equal to or greater than 5 inches per roll (at least 3 yards, unstretched)

A6426 conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 3 inches and less than 5 inches per roll (at least 3 yards, unstretched)

A6428 conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to 5 inches per roll (at least 3 yards, unstretched)

Y6022, Fork and strap replacement is replaced with

E0997, Caster with a fork and

E0998, Caster without a fork

Y6025RR, Outdoor oxygen liquid, tank with regulator is replaced by

E0434RR, Portable liquid oxygen system, rental, includes portable system and supply

Y6026, Solid foot plate is replaced with

K0042, Standard foot plate, ea.

Y603RR, Humidifier (CASE) Ser-u-pak, feed sets including jars

E0550, Humidifier, durable, glass or autoclavable type for use with regulator or flow meter

Y6032, Augmentative communication device is replaced with

K0547, Accessory for speech communication device

Y6035LL, Compressor 50 PSI outlet including filters is replaced by

E0565, compressor, air power, source for equipment which is not self-contained or cylinder driven

Y6040, Non-disposable circuit for patient owned ventilator

A4618, Breathing circuits patient owned ventilator

Y6047, Zippy wheeled stander is replaced with

S8470, Positioning device, stander for use by patient who is unable to stand independently

Y6066, Head harness pulley system is replaced with

E0942, Cervical head harness/halter

Y6071, Overnight reading/oximeter

A0445, Oximeter device for measuring blood oxygen levels non-invasively (Bill one unit)

Y6073, Airless tube/liner tube is replaced with

K0093, Rear wheel zero pressure tire tube (insert)

K0097, Wheel zero pressure tire tube

Y6079, Toilet seat, support/reducer rig, adj. opening

E0244 Raised toilet seat

Y6095, Pari LC jet nebulizer is replaced by

A7005, Administration set, with small volume non-filled pneumatic nebulizer

Y6096, Enteral feeding supply kit for long term care facility

B4034, Enteral feeding supply kit, syringe fed, per day

B4035, Enteral feeding supply kit, pump fee, per day

Y6100, Solid back insert, wheelchair including hardware is replaced with

K0023, Solid back insert, planar back, single density foam

Y6103, Speaking valve tracheostomy is replaced by
L8501, Tracheostomy speaking valve
Y6125, Swing away leg rests with foot plate is replaced with
E0990, Elevating leg rest, each
Y6126, Pneumatic tire tube is replaced by
K0068, Pneumatic tire tube
Y6132, Oxygen holder for wheelchair is replaced with
K0104, Cylinder tank carrier
Y9088, Jobst garment is replaced with
A6510, compression burn garment, trunk, including arms down to leg openings (leotard), custom fabricated.
A6511, compression burn garment, lower trunk including leg opening (panty), custom fabricated.
A6512, Compression burn garment, not otherwise classified.
Y9090, Helmet, and Y9091, Helmet with face guard are replaced by
E0701, Helmet with face guard and soft interface material, prefabricated

The following codes have been closed:
Y0324, Adhesive Gaskets and Supports, each
Y0350, TED stockings to knee
Y0354, Arm brace molded over plastic
Y0376, Molded leather calf corset
Y0396. Double adjustable ankle, short/long leg
Y0428, IV flow control device
Y0432, PRN adapter caps for peripheral line IV catheter
Y0433, Central line needle w/locking device
Y0436, Cartridge for pancreatic pump
Y0553, Seat frame
Y0554, Side lying board
Y0557, Trunk support block
Y0561, Smart box programmer speed control
Y0562, Air splint
Y0566, Positioning devise, Head ie hands
Y0565, Ball bearing feeder system
Y0675, Design and assembly power wheelchair sip n blow head control
Y0676, Assembly power wheelchair, additional controls
Y5000RR, Kilogram scale
Y5555, Enuresis Alarm
Y5999, Quidel Quickview one step Hpylori test kit
Y6004, 4 oz. Mini infant drain pouch
Y6017, Seating system pads for tilt in space wheelchair
Y6018, Hydraulic Bath Chair with spout connector
Y6020RR, Oxygen analyzer
Y6024, Knee blockers
Y6036, Mini kit with filter, exhalation check valve mouth piece
Y6041, Flip down hardware for an extended headrest
Y6042, Padded transfer bench
Y6043, 9" caster fork/tire/tube/wheel electric wheelchair
Y6044, Pediatric reacher
Y6045, Supine stander
Y6046, Positioning support bath system with head rest
Y6048, Swivel walker, small custom
Y6049, Swivel walker, large custom
Y6052, Orthopedic care seat, positioning
Y6067, Joystick extension
Y6063, 3-way 30 cc balloon, nonallergicnic, special coating for continuous irrigation
Y6065, Ambu bag
Y6078, E Z portable blow up bath tub
Y6081, Feeder seat, any brand
Y6084, wheelchair – Joy stick replacement
Y6091, ABD or similar bandage 7x10 inches
Y6098, Med-Ject, insulin air injector
Y6101, Power elevating leg rests
Y6106, Push cane for power wheel chair
Y6110, Scoliosis pad, cushion, custom, for wheelchair

Y6111, Reverse Walker conversion kit
Y6115, Normal saline, 3 cc vial
Y6120, Hip guide/cushion for wheelchair
Y6127, Wheelchair positioning headrest
Y6129, Shoe Holder, each
Y6130, Adductor pads, abductor pads or hip guide
Y6131, Full anterior positioning chest support
Y6136, Hardware, pan, all attachments for contour back and seat, are replaced by
Y8025, Office surgery kit/podiatrists only
Y9005, Gram Scale
Y9066, Isothermol breathing circuit/ped/adult
Y9072, Bags/enteral, thirty/month
Y9093, Mouth Rinse ☐

03 - 27 Audiology

Beginning July 1, 2003, Audiology services that were eliminated for non-pregnant adults aged 21 and older are restored to the same level and coverage as prior to July 1, 2002. The same criteria and prior authorization requirements will be implemented.

The following codes are replaced:

Y2100, Assistive Listening Device is replaced by
V5274, Assistive Listening Device
Y5500, Diagnostic Audiology Evaluation is replaced by
92557, Comprehensive audiometry threshold evaluation and speech recognition
Y1310, Electronystagmus test is replaced by
92541, Spontaneous nystagmus test
92542, Positional nystagmus test, minimum of four positions
Y1311, Electrophysiological tests is replaced by
92586, Auditory evoked potentials for evoked response audiometry and/or testing of the CNS, limited.
Y1321, Hearing aid mold, special needs children is replaced by
V5275, Ear impression, each
Y0360,Y0366, Y0369, Y0370, Y0372, hearing aid repair codes are replaced with
V5014, Repair/modification of hearing aid

Beginning July 1, 2003, Audiology services that were eliminated to non-pregnant adults aged 21 and older are restored to the same level and coverage as prior to July 1, 2002. The same criteria and prior authorization requirements will be implemented. ☐

03 - 28 Dental Program

Endodontics

Effective immediately, Root canals are <u>not</u> covered on second and third molars for all adults in traditional Medicaid, including pregnant women. A typographical error on page 4 of the Medicaid Dental Provider Manual is corrected which inadvertently allowed root canals on second or third molars for pregnant women.

Dental Coding Change and Reimbursement

On April 2, 2003, Medicaid implemented a dental coding change. The change in the dental coding eliminated codes specifically for primary teeth and merged them into codes for both primary and permanent teeth, but resulted in a substantial increase to the Medicaid budget. In order to compensate for the budget impact, codes D2140, D2150, D2160, D2161, D2391, and D7140 have been re-priced. The resulting reimbursement still provides for a fee increase consistent with the fee increase implemented in October of 2002 and results in a major fee increase for treating primary teeth. ☐

03 - 29 Transportation

Closed codes:
Y1120, Non-emergency round trip (taxi)
Y1130, Specialized Van round trip
Y1165, Non-specialized van, one rider per mile
Y1166, Non-specialized van, two riders per mile
Y1167, Non-specialized van, three or more riders per mile
Y1170, Base rate for negotiated trips (51 miles and over), one way
Y1171, Mileage negotiated trips only (51 miles and over), one way
Y6053, Out of state trans
Y6054, Out of state airfare
Y6056, Out of state housing

Closed codes being replaced:
Y1111, Utah Flextran service per trip is being replaced by
A0120, Non-emergency transportation; mini bus, mt. area trans, or other ☐

03 - 30 Vision

Beginning July 1, 2003

The following codes are replaced:

Y0271, Contact, rigid is replaced by
V2510, Contact lens, gas permeable, spherical, per lens
Y0260, Frame repair is replaced by
V2799, Vision service, miscellaneous
Y0363, Eye artificial, rebuilding is replaced by
V2624. polishing/resurfacing of ocular prosthesis

The following codes are closed:
Y0269, Contact lens, hard, unilateral replacement
Y0272, Contact lens, oxygen permeable, unilateral replacement
☐

03 - 31 Physical Therapy/Occupational Therapy

Beginning July 1, 2003, Physical Therapy and Occupational Therapy services that were eliminated for non-pregnant adults aged 21 and older are restored to the same level and coverage as prior to January. The same limits and prior authorization requirements will apply.

Closed codes:

Y0012, PT, unlisted procedure ☐

03 - 32 ATTENTION: Methadone Maintenance Providers

Please note that effective October 1, 2003, current Medicaid Y codes will be replaced with standardized HCPCs procedure codes in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The current Medicaid Y code for methadone maintenance, Y6080, will be replaced with H0020. For dates of service on or after October 1, 2003, you must use this new code. If you have questions, contact Merrila Erickson at 538-6501. ☐

03 - 33 Speech and Language

Beginning July 1, 2003, Speech and Language services that were eliminated for non-pregnant adults aged 21 and older are restored to the same level and coverage as prior to July 1, 2002. The same criteria and prior authorization requirements will be implemented. See Medicaid Speech and Language Provider Manual updates.

Opened codes:

92510, Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing therapeutic services) with or without speech processor programming

Closed codes and replacements:

Y2000, Electrolarynx/electronic speech aid is replaced by
L8507, Tracheo-esophageal voice prothesis, inserted by patient
L8509, Tracheo-esophageal voice prothesis, inserted by provider
Y1011, Speech language therapy , 30 minutes, individual, and Y1012, speech language therapy, 45 minutes, individual, and Y1013, speech language therapy, 60 minutes, individual are replaced by
92507, Treatment of speech, language, voice, communication, individual
Y1014, Dysphasia therapy is replaced by
92610, Evaluation swallowing and oral fucntion
Y1021, Speech language therapy, 30 minutes, group, and Y1022, speech language therapy, 45 minutes, group, and Y1023, speech language therapy, 60 minutes, group are replaced with
92508, Treatment of speech, language, voice, communication, group.
Y1026, Basic evaluation speech therapy, 30 minutes, and Y1027, Intermediate evaluation speech therapy, 45 minutes, and Y1028, Comprehensive evaluation speech therapy, 60 minutes are replaced by
92506, Evaluation speech, language voice, communication auditory processing

Codes which are closed with no replacement:

Y1016, Training caregiver in dysphasia
Y1025, Speech, language, 60 minute consultation
Y1030, Post assessment/speech language pathologist

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03 - 34 Enhanced Services for Pregnant Women

Effective October 1, 2003, to comply with HIPPA regulations, the Utah Medicaid Program Manual for Enhanced Services for Pregnant Women has been reviewed. The state only "Y" codes have been converted either to HCPCS alphanumeric codes or to CPT codes. To account for program utilization and differentiate between CNM services and physician services, the designated provider type will be used for editing and payment of claims. Two defined services allow for participation of a Certified Family Nurse Practitioner (CFNP) where one is employed in a health department or community clinic. Modifiers have been added to differentiate the work of a CNM and a CFNP in billing.

Minor changes have been made in the Program Manual which is attached. Please review it carefully and note the changes that affect you. ☐

03 - 35 Podiatry Code changes

J0810, Injection, cortisone, up to 50 and J2970, Injection, methicillin sodium up to 1 gm. have been closed with no replacement by HCPCs in 2002.

As a result of these changes, these codes are no longer available within the Medicaid podiatry program. ☐

03 - 36 OTC List

The pharmacy OTC list has revisions to reflect market conditions. Select products are no longer covered in nursing homes since these products should now be carried as floor stock by the nursing home.

Effective 7/1/04, the DUR Board had added loratadine and loratadine decongestant formulations along with brand name formulations. These products have a Utah MAC. ☐

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03 - 37 COX-2 AGENTS TO BE PLACED ON PRIOR APPROVAL!!!

The COX-2 Inhibitors have been placed on prior approval (PA) by the DUR Board effective the 3rd quarter of 2003 .

Seniors age 65 and over will be covered **without PA.**
Prior approval (PA) will be required for clients < age 65. The COX-2 agents will be covered if one or more of the following is documented:

Telephone Prior - pharmacy:

a. Covered as an analgesic for 10 days with simple telephone prior.

Written Prior, Physician, copy from patient chart documenting:

a. Covered as an anti-inflammatory: for client having concomitant diagnosed GERD, Barrett's Syndrome, peptic ulcer, or gastro hypersecretory conditions or documented gastric bleeding caused by other NSAIDS.
b. Covered as an anti-inflammatory if client on concomitant anticoagulant therapy
c. Covered as an anti-inflammatory for clients on concomitant oral corticosteroid therapy
d. Covered as an anti-inflammatory for clients with documented history of ulcers.

Dosing is limited to labeled amounts of: 30 units/30 days for Vioxx or Bextra; up to 60 units/30 days of Celebrex. ☐

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03 - 38 ACCESS TO LONG ACTING NARCOTICS and ACTIQ TO BE RESTRICTED!!!

The DUR Board has passed sweeping reform for these agents which will become effective the 4th quarter of 2003. Short acting narcotics are not affected by this policy excepting fentanyl.

Fentanyl citrate (Actiq) lozenges will be covered only for diagnoses of malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature. An absolute cumulative limit of 120 units, any combination of strengths, per any 30 days is maximum amount covered. Prescribers must write the appropriate ICD.9 Code (first four digits) on the prescription.

Regarding long acting narcotic formulations for non-malignant chronic pain, the DUR Board has set a guideline for maximum daily dose of: morphine sulfate SR 150mg or 90 capsules/tablets per any 30 day period; Duragesic up to and including 75mcg - 15 patches per any 30-day period; OxyContin up to 100mg daily or 90 tablets per any 30-day period. Duragesic 100mcg is not covered for chronic non-malignant pain. Methadone 50mg per day maximum. Physicians may petition the DUR Board for a patient specific override exceeding these guidelines.

For clients with malignant neoplasms, carcinoma in situ, or neoplasms of unspecified nature, an override may be gained by the physician writing in an appropriate 4 digit ICD.9 code which the pharmacist must enter into the diagnoses field. The drug program will be programmed so that there will be no therapeutic duplication allowed for the long acting narcotics sometime in the 3rd for 4th quarter of 2003. ☐

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03 - 39 Brand Name Drugs

The Pharmacy Practice Act has been modified to require the use of generic drugs were ever possible. When multi source AB rated generic drugs are available, the physician must obtain a prior approval for a brand name drug. The prior approval is predicated on a FAXed copy of documentation in the patient's chart that shows the generic has been tried and failed due to a specified adverse drug reaction or loss of efficacy. The pharmacist must still use the DAW override key to obtain full payment for the brand name. ☐

03 - 40 Pharmacy Point-Of-Sale Software

All pharmacy drug claims must be billed using the new NCPDP 5.1 software supporting pharmacy point-of-sale. NCPDP5.1 will be up and running July 1, 2003 and the Division will accept claims in either NCPDP 3.2 or NCPDP 5.1. Effective October 17, 2003, only claims submitted in NCPDP 5.1 will be accepted. ☐

03 - 41 Drug Returns in Nursing Homes

The Pharmacy Practice Act has been modified to allow the return of unused medications for Medicaid nursing home clients. This modification essentially changed ownership of an unused drug from the client to Medicaid. Nursing homes must return these unused drugs monthly to the pharmacy which in turn must credit the drug value back to Medicaid. ☐

03 - 42 Hospital Outpatient & Ambulatory Surgical Center (ASC) Payment System

The Department of Health, Division of Health Care Financing will be initiating a prospective system for the payment of ambulatory care services. Consisting mainly of hospital outpatient and ASC payments the system will be designed to meet the needs of the Medicaid program as well as the establishing a fair payment policy for ambulatory care services. The projected effective date is January 1, 2004. Providers and all interested parties will be informed of the progress of the initiative as it advances. ☐

03 - 43 Other HIPPA Related Y Code Changes

The following Y codes will be closed when programming is completed; the listed replacement HCPCS will be reimbursed at the same rate and conditions as the Y code or the CPT code.

Y code
Y7600 Anesthesia sedation for imaging replaced by CPT sedation codes 99141or 99142
Y8880 Dietitian Special HC needs child by Telehealth replaced by S9470 with GT modifier
Y9300 RN Telehealth homecare 15 minute(1unit) replaced by T1002 w GT modifier
Y9301 RN Telehealth homecare 30 minutes(2unit) replaced by T1002 w GT modifier
Y9302 Dietician Counseling Telehealth Homecare replaced by S9470 w GT modifier
Y9590 Nutrition Assessment & Care Plan replaced by 97802 in 15 minute increments (4 units)
Y9595 Nutritional Therapy replaced by 97803 in 15 minute increments (4 units)
Y0944 Diabetes Self Management Training replaced by S9455
Y9007 Directly observed TB therapy office replaced by T1502
Y9008 Outreach TB DOT replaced by H0033
Y0458 San Juan Home Health Differential—The Modifier TN must be placed on the first line of the claim along with the appropriate home health code.

Y codes which have been closed because there was not evidence of recent use, the code is no longer needed and/or there is not an appropriate HCPCS code to adapt for the purpose of the code.
Y1350 CRNA supplies -office anesthesia
Y4681 MMR vaccine last
Y4773 Hepatitis B vaccine
Y4797 HIB/Haemophilus influenza
Y5410 Physician HIV/AIDS case management
Y6666 Home Visit TB patient
Y6700 Primary care South Davis
Y6705 Initial consult South Davis specialist
Y6710 Followup consult South Davis
Y7777 Disease oriented CM
Y9006 TB targeted CM
Y9240 TB unit daily rate

Y9550 Outpatient Rehabilitation Day care

The Y code conversions required under HIPPA and mentioned above were added to the physicians or home health manual. ☐

03 - 44 CPT Code Changes

CPT Codes Not Covered

Medicaid does not cover the CPT codes listed below. The Medicaid list states these codes are "NOT A BENEFIT." Descriptors in the list below are abbreviated.
10040 Acne Surgery (marsupialization, opening removal multiple milia, cysts, comedones, pustules)
11201 Removal skin tag ... each additional ten lesions
90657 Influenza vaccine, split, 6-35 months (covered in vaccine for children program)

CPT Codes Requiring Prior Authorization

The CPT codes listed below are covered only with prior authorization, either written or telephone as indicated. Criteria are stated on the list dated April 2003.
Telephone Prior Approval Required for Codes Listed below
19357 Breast Reconstruction with tissue expander

Codes Limited by Age

The following CPT Codes are limited by age:
90633 Hepatitis A vaccine Ped/Adolescent, 2 dose, IM
90634 Hepatitis A vaccine Ped/Adolescent, 3 dose, IM
90700 Diphtheria tetanus toxoid (DTAP), IM

CPT Code Requiring Documentation with Claim

An unlisted CPT code and the following codes do not require prior authorization. However, it the provider must attach documentation to the claim for staff review.
11200 Removal of skin tags ☐

03 - 45 CPT Codes With Other Criteria

Two other groups of CPT codes do not require prior authorization, but are subject to new Medicaid criteria.
Benign Lesions: The code 11200–Skin Tag removal was added to the Benign lesion criteria #34. Documentation will be required for review supporting medical necessity and that the purpose of the procedure was not cosmetic.

New Criteria or Changes to Existing Criteria

Vagal Neurostimulator Criteria#32 A, the criterion was revised to require evidence epilepsy is refractive to four drugs, a statement of device benefit from the neurologist, and review of required tests needed with medical record documentation.

Benign Lesion Criteria # 34, The code 12000–skin tag removal will now require submission of documentation supporting that the service is not cosmetic. The additional skin tag lesion code 12001 has been closed.

Medical and Surgical Procedures List and Hospital Surgical Procedures Some inconsistencies were identified between the CPT list and the Hospital Surgical Procedure list. Both lists have been corrected.

Physician Manual, SECTION 2, Addendum

Under limitations section F. Specimen collection. When the codes 85014, 85610, 83036 and 86318 with modifier QW, the code G0001 is mutually exclusive or not covered for blood tests obtained by finger stick

Under specific noncovered services **2. s.** Some regional or local anesthesia procedures don't require monitoring according to Medicare and may be completed by the surgeon. An example of this type of service is code 01995. Regional anesthesia provided by the surgeon is included within the global surgical fee and is not separately reimbursable. When monitoring is required during regional or local anesthesia, services are payable to the anesthesiologist. ☐

03 - 46 Laboratory

As described in the April 2002 MIB, code GOOO1–venipuncture is not a covered service when billed with 82948 or 85013. Any blood test obtained by heel or finger stick will post a mutually exclusive edit with G0001. The following codes have been added as mutually exclusive to G0001: 85014–hematocrit, 85610–Prothrombin time, 83036–glycated hemoglobin, and 86318 –immunoassay for infectious agent by reagent strip when submitted with the modifier QW. ☐

03 - 47 Vaccination Issues in Adults

There is concern related to the frequency and conditions of use of some vaccines in adults. This information is provided to update providers on adult immunization based on CDC guidelines.

Hepatitis: Hepatitis A vaccine is typically provided initially and then the second dose six months later. Hepatitis B has a three dose requirement so that after the initial dose, one is given one to two months later, and the third is given at least six months but never more than twelve months from the first vaccine. Data warehouse review of vaccine administration over the last two years indicated that pediatric/adolescent hepatitis A and hepatitis B vaccines have been provided to patients more than 19 years of age. In some cases an adult dose was provided one month to two months later. Documentation may be required to explain why a pediatric vaccine is administered to an adult. There is a new vaccine "Twinex" which includes an adult formula of hepatitis A and Hepatitis B. After the initial vaccine, one is given at one to two months later and the third vaccination is given six months from the first. The efficacy of these vaccines when mixed between the combination and the single versions have just been reviewed by the Division of Viral Hepatitis at CDC. Dr. William Atkinson, CDC, provides the following information, if the first immunization is the "Twinrix," the hepatitis B portion counts, but the hepatitis A portion does not count. Followup with two hepatitis B vaccinations separated by at least two months and two doses of hepatitis A vaccine separated by at least six months. If two doses of "Twinrix" are given, the schedule may be completed with one dose of "Twinrix," or one does of adult hepatitis A vaccine and one dose of adult hepatitis B vaccine on the appropriate schedule. If one dose of adult hepatitis A and hepatitis B, the vaccination may be completed with two doses of "Twinrix," or one dose of hepatitis A vaccine and two doses of hepatitis B vaccine on the appropriate schedule.

Influenza: A second Influenza vaccination has been provided one week to two months from the first vaccination. Adults should receive only one influenza vaccine per influenza season. Should conditions occur where the patient receives one influenza vaccination in September requires a second vaccination, documentation for medical necessity may be required. Payment for additional doses given closer than four months apart will be denied in the future.

Pneumovax: A second pneumovax vaccination has been given two weeks to two months from the first. The Centers for Disease Control and Prevention states that in most cases one dose of pneumovax is sufficient. If the first dose was provided prior to age 65, a second dose may be indicated. The pneumovax vaccine **must be separated by more than five years.** When given sooner than five years, there are adverse reactions which may occur from this vaccine.

Tetanus/Diphtheria: A Tetanus Diphtheria (Td) booster should be given every ten years. Since diphtheria has resurfaced in Europe, the combination vaccine should be provided. In the event of a deep dirty wound the tetanus toxoid should be repeated if the booster was more than five years ago. For updates on adult vaccination visit the Centers for Disease Control and Prevention web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf ☐

03 - 48 Medicaid Announces the Results of Two Child Health Measures

State Medicaid programs are required to report on the percentage of children who receive well-child (CHEC) visits. The report format is known as the CMS-416. The results reported for federal fiscal year 2002 (01 October 2001 through 30 September 2002) show a decline in the percentage of Medicaid children receiving well-child (CHEC) exams.

The percentage of children who received well child visits changed from 58% to 56%. The percentage of all children, except for those in the 19 to 21 age group decreased. However, the 1-2, 3-5 and 15-18 year old groups decreased by only 1 percentage point. The federal target level for the overall participation level is 80%.

The numbers of children receiving dental services increased. DHCF reported to CMS the participation rate for children over age one who receive any dental service. In federal fiscal year 2002, 35.26% of Medicaid enrolled children received any dental service. This is an increase over the previous years we reported. In federal fiscal year 2000, 33.34% of our children received any dental service. In federal fiscal year 2001, 32.76% percent of our children received any dental service.

Utah reported the following for federal fiscal year 2002:

Age group	Total	< 1	1-2	3 -5	6 -9	10 -14	15-18	19 -21
# of children	145,036ü	28,081ü	21,667ü	25,931ü	22,134ü	21,495ü	14,054ü	5,433ú
Participation Ratio	56%ú	81%ú	51%	48%	40%ú	36%ú	40%	27%ü
# of children referred for follow up treatment	2ú	2ú	0ú	0ú	0ú	0ú	0ú	0
Children who received preventive dental services	10,843	8	622	2,727	3,373	3,023	1,000	90
Children receiving blood lead level tests	1,121ü	341ü	635ü	142ü				

- The number of children reflects an unduplicated count of all children enrolled in Medicaid during the reporting period.
- The '*Participation Ratio*' reflects the percent of children who received at least one well-child (CHEC) visit during the time period. Note this does not mean that children received all visits recommended on our periodicity schedule, but that this percent of the children received at least one visit.
- The number of children referred for follow up treatment from one of those well-child (CHEC) visits is very low. We believe that health care providers do refer children for follow up treatment based on what they find during the well-child visit, but are not informing us. Please remember to use the CF modifier with the CPT4 well-child code when submitting claims.
- The number of children who receive preventive dental services is low. We encourage families to take children to the dentist for preventive care twice a year. Please help us by reminding parents of the importance of oral health.
- The number of children who receive blood lead level tests is also very low. Children ages 0 to 72 months should have a verbal assessment of their risk for exposure to lead. Children at high risk and those who are 12 and 24 months should have a blood lead level test.
- The arrows indicate an increase, decrease or no change from last year.

Please refer to the CHEC Provider Manual for information on protocols for the well-child (CHEC) visits.

All states now participate in the Centers for Medicare and Medicaid Services Government Program and Results Act (GPRA) Immunization Measure. Utah was one of the original states which agreed to participate. The Immunization Program in the Division of Community and Family Health Maternal and Child Health Bureau has been an active partner in this measure.

We chose to define 'fully immunized' as 4 DtaP, 3 Polio, 1 MMR, 3 Hep B, and 3 Hib. We selected a sample of 400 children who turned two during the base line year and who had been enrolled in Medicaid for at least six continuous months. We looked at records from our MMIS claims system and the Utah Immunization Information System (USIIS). We received more complete data from these sources this year.

The information collected was input to a CASA program. For federal fiscal year 1999, our baseline year, we could identify only 19% of the children in our sample as fully immunized. For federal fiscal year 2000, we identified that 27.75% of all children in our sample were fully immunized. For federal fiscal year 2001, we identified 31.25% of the children in our sample were fully immunized. In federal fiscal year 2002, Utah reported 43.85% of the children in our sample were fully immunized. These rates show progress, and we still have a long way to go.

For more information contact Marilyn Haynes-Brokopp, CHEC Coordinator at 801-538-6206 or Julie Olson, Bureau Director at 801-538-6303. ☐

03 - 49 Circumcision Procedures No Longer Covered by Medicaid

Effective on or after July 1, 2003, circumcision procedures will no longer be covered by Utah Medicaid. For several years, there has been a national campaign to eliminate circumcision from funding because of the elective, non-therapeutic nature of the procedure rather than medical necessity. The Legislative Appropriation from the last session of the Utah Legislature did not provide funding to continue coverage. Accordingly, the following CPT codes for circumcision by clamp or surgical excision will be closed: 54150, 54152, 54160, 54161, and 54163. If there is a verifiable, medically necessary indication for a circumcision, an exception may be made through the prior authorization process and review of the request by the Utilization Review Committee. [Refer to prior authorization process, SECTION 1, pages 33 and 34 of the Medicaid Physician Provider manual.] A family may choose to have the circumcision procedure completed, but must work out a private payment arrangement with the physician.

This information has been placed in the Physician Manual, SECTION 2, page 40, Non-covered services. The prior authorization list has also been updated and replacement pages are included. ☐

03 - 50 Observation Services

A policy covering *Observation Services* was sent to Hospital Administrators by a special Bulletin dated February 3, 2003, and added to the Medicaid Hospital Manual with the April 2003 Bulletin. This policy was developed in response to Medicaid audits of observation services which identified unusual utilization patterns and billing. Continuing review identified need for clarification of the policy. Changes have been made and added to the Hospital Manual, SECTION 2, pages 17 -19, Item #16. Pages to update your Manual are attached. ☐

03 - 51 Post Anesthesia Recovery Services

Recovery services following a surgical procedure may vary in scope depending on the type and length of the anesthesia procedure. A need for some general guidelines associated with recovery services became apparent during recent audits. Guidelines have been developed and added to the Hospital Manual, SECTION 2, pages 19-20, Items #17 and #18. Pages to update your Manual are attached. ☐

03 - 52 Attention: Mental Health Centers and Substance Abuse Providers

Procedure Code Standardization
Please note that effective October 1, 2003, current Medicaid Y codes will be replaced with standardized HCPCs procedure codes in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For dates of service on or after October 1, 2003, the new procedure codes must be used. Please refer to procedure code crosswalks provided at the March 6, 2003 training to assist in your procedure code conversion process. The crosswalks can also be accessed at: www.health.utah.gov/hipaa/medicaid_pcn.htm

The Utah Medicaid Provider Manual for Mental Health Centers, the Utah Medicaid Provider Manual, Targeted Case Management for the Chronically Mentally Ill Manual and the Utah Medicaid Provider Manual, Substance Abuse Treatment Services and Targeted Case Management for Substance Abuse will be revised to include the new procedure codes and will be published in the October 2003 Medicaid Information Bulletin. Please contact Merrila Erickson at 538-6501 if there are questions. ☐

03 - 53 Attention: Licensed Psychologists

Procedure Code Standardization
Please note that effective October 1, 2003, current Medicaid Y codes will be replaced with standardized HCPCs procedure codes in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For dates of service on or after October 1, 2003, the new procedure codes must be used.

Procedure codes will be changed as follows:

Service	Current Procedure Code	New Procedure Code
Mental Health Evaluation	Y3200, Y3205 Y3206, Y3207	90801/90802, per 15 minutes
Psychological Testing	Y3220, Y3225, Y3211, Y3212	96100, 96105, 96110, 96111, 96115, 96117, per hour
Individual Mental Health Therapy (Family Therapy)	Y3220, Y3225, Y3213, Y3214	90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, & 90846 and 90847 (time frames built into codes)
Group Mental Health Therapy	Y3240, 3245, 3216, 3217	90849, 90853, 90857, per 15 minutes

A procedure code crosswalk showing the code changes can also be accessed at:
www.health.utah.gov/hipaa/medicaid_pcn.htm

The Utah Medicaid Provider Manual-Psychology Services will be revised to include the new procedure codes and will be published in the October 2003 Medicaid Information Bulletin. Please contact Merrila Erickson at 538-6501 if there are questions. ☐

03 - 54 Attention: Targeted Case Management for the Homeless Providers

Procedure Code Standardization

Please note that effective October 1, 2003, the current Medicaid Y code for targeted case management will be replaced with a standardized HCPCs procedure code in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For dates of service on or after October 1, 2003, the new procedure codes must be used.

Procedure codes will be changed as follows:

Y3110 and Y3115 will be replaced with T1017.

The Utah Medicaid Provider Manual-Targeted Case Management for the Homeless will be revised to include the new procedure code and will be published in the October 2003 Medicaid Information Bulletin.

Please contact Merrila Erickson at 538-6501 if there are questions. ☐

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03 - 55 Attention: Diagnostic and Rehabilitative Mental Health Contractors - Prepaid Mental Health Plan-Exempted Subsidized Adoptive Children

Procedure Code Standardization
Please note that effective October 1, 2003, the current Medicaid Y codes for diagnostic and rehabilitative mental health services will be replaced with standardized HCPCs procedure codes in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
For dates of service on or after October 1, 2003, the new procedure codes must be used.
This means if you are providing services to subsidized adoptive children exempted from the Prepaid Mental Health Plan for outpatient mental health care, and therefore are billing Medicaid directly for services provided, you must use the new procedure codes for services provided on or after October 1, 2003.

The Utah Medicaid Provider Manual-Diagnostic and Rehabilitative Mental Health Services by DHS Contractors will be revised to include the new procedure codes and will be published in the October 2003 Medicaid Information Bulletin.

So that you may begin the procedure code conversion process, procedure codes will be changed as follows:

Service	Current Procedure Code	Procedure Code
Mental Health Evaluation	Y0480 & Y0488	90801/90802, per 15 minutes
Psychological Testing	Y0481	96100, 96105, 96110, 96111, 96115, 96117, per hour
Individual Mental Health Therapy	Y0482	90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828
(Family Therapy)		90846 & 90847 (time frames built into codes)
Group Mental Health Therapy	Y0483	90849, 90853, 90857, per 15 minutes
Medication Management/MD	Y0484	90862
Medication Management/RN	Y0485	90862 with TD modifier
Group Skills Development	Y0486	H2017, per 15 minutes
Intensive Group Skills Development	Y0487	H2017 with U2 modifier, per 15 minutes

A procedure cross walk may also be accessed at: www.health.utah.gov/hipaa/medicaid_pcn.htm

Please contact Merrila Erickson at 538-6501 if there are questions. ☐

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03 - 56 Inpatient Hospital, Billing Third Party Claim

SECTION 1, General Information, Chapter 11 - 4, Billing Third Parties, states the general policy in regard to patients who have liable third parties in addition to Medicaid.

Effective July 1, 2003, the contractual adjustment or TPL write-off should not be reported in the third party payment. Payer paid amount and patient liability must be reported. ☐

03 - 57 Certified Registered Nurse-Midwife Services

Effective October 1, 2003, to comply with HIPPA regulations, the Utah medicaid program manual for Certified Registered Nurse Midwives has been reviewed. The state only "Y" codes have been converted to CPT codes. To account for program utilization and differentiate between CNM services and physician services, the designated provider type will be used for editing and payment of claims. For two specific assessment codes established by policy, a modifier has been added to be used by a CNM or a CFNP in the appropriate circumstances.

Minor changes have been made throughout Section 2 of the Certified Registered Nurse-Midwife Provider Manul which is attached. Please check carefully to note the changes which affect you. SECTION 3 – *Birthing Center Services,* does not have changes because there are no facilities in use at the present time. ☐

03 - 58 Medicaid Billing for Third Party Payment

Effective July 1, 2003, Medicaid will require the completion of an Insurance Payment Report Claim Attachment form (IPR) for reporting of third party liability (TPL) payments on paper claim submissions. The form and instructions are attached. They should be placed in the General Attachments Section of the Medicaid Provider Manual. A copy will be on-line at http://health.utah.gov/medicaid/ipr.pdf

Claims containing third party payment information should be submitted to Medicaid after payment is received from all other liable parties. Claims may be submitted on paper or electronically.

Paper:
- Third party pays the service, report the payment amount in the appropriate box. Do not include contractual adjustments, TPL write-offs or patient payments. It is not necessary to complete the Insurance Payment Report Claim Attachment form or to send an EOB.
- Third party pays $0 or denies the service, Medicaid requires the completion of an Insurance Payment Report Claim Attachment form. Claims submitted without the IPR form will be returned.
- Medicare Crossover (COB). When Health Care Financing takes over processing of the Medicaid Crossover claims, an Insurance Payment Report Claim Attachment form will be required regardless of the payment amount. Claims submitted without the IPR form will be returned.

Electronic:
- Third party pays the service, report the payer paid amount and patient liability. Do not include contractual adjustments, third party liability (TPL) write-offs or patient payments in the payer paid amount.
- Third party pays $0 or denies the service, send the claim to Medicaid and FAX the complete Explanation of Benefits (EOB) directly to the Health Care Claims team in the Office of Recovery Services at (801)536-8513.
- If using the ANSI X12 Version 4010, it is not necessary to submit an EOB to the Office of Recovery Services for a $0 payment or denial. Complete the other payer payment information including payer paid amount, patient liability and reason codes. ☐

Separate Bulletins Issued for Non-Traditional Medicaid Plan and Primary Care Network

The Division of Health Care Financing issues separate bulletins to inform providers of changes in the Non-Traditional Medicaid Plan and the Primary Care Network Program. The bulletins are mailed only to enrolled providers who are affected by information in the bulletins.

The July 2003 NTM bulletin will be issued for the following types of services: Audiology, Physician, and Speech Pathology.

The July 2003 PCN bulletin will be issued for the following types of services: Audiology, Hospital, and Physician.

All bulletins are available on the Medicaid Provider's web site: http://health.utah.gov/medicaid/html/provider.html

Bulletins are under the headings Medicaid Information Bulletins, Non-Traditional Medicaid Plan, and Primary Care Plan. Contact Medicaid Information if you want a printed NTM or PCN bulletin that is not included with this Medicaid bulletin.

03 - 59 Cross-Over Claims to be Processed by Health Care Financing Beginning October 1, 2003

On October 1, 2003, the Division of Health Care Financing will begin processing the Medicaid portion of Medicare cross-over claims for patients who have both Medicare and Medicaid coverage. When implemented, providers should contact Medicaid Information concerning the Medicaid portion of cross-over claims, rather than contacting the Medicare Intermediary in Utah (Blue Cross/Blue Shield) as is done now.

Provider Manuals Modified
Two sections of the Utah Medicaid Provider Manual are updated to include the new billing address and other information relevant to Crossover claims.

SECTION 1, GENERAL INFORMATION,
Chapter 11 - 7, Filing Crossover Claims, page number 41.
Utah Medicaid Provider Manual for Hospital Services, SECTION 2, Chapter 5, BILLING, item D, Crossover Claims with EOMB attachment, page 21. There is a link to the current version of SECTION 1 on the Medicaid Provider's web site: http://health.utah.gov/medicaid/provider/html/provider.html A vertical line marks where text was changed. A reminder of this change in billing procedure will be posted on the Medicaid Provider's WHATS NEW site: http://health.utah.gov/medicaid/provider/html/what_s_new.html

Manual changes

11 - 6 Medicare/Medicaid Coordination of Benefits (Crossover Claims)
Effective October 1, 2003, the Division of Health Care Financing processes the Medicaid portion of Medicare cross-over claims for patients who have both Medicare and Medicaid coverage.

A Medicare and Medicaid Coordination of Benefit Claim is a single claim for a Medicare and Medicaid eligible client for Medicare covered services. The initial claim should be submitted directly to Medicare. To coordinate benefits, if the provider accepts assignment for Medicare Part A and Part B claims, the claim will be sent automatically from Medicare to Medicaid. The Medicare payment and Medicaid payment are considered payment in full. The Medicaid Crossover payment is reported on the Medicaid Remittance Statement under the section for Crossover claims.

11 - 7 Filing Medicare/Medicaid Coordination of Benefits (Crossover Claims)
If the Provider accepts assignment, the claim will be processed automatically by Medicaid. If Medicare and Medicaid Coordination of Benefits are not processed automatically, the claim should be submitted directly to Medicaid either electronically or by paper. The deadline for submitting a COB for Medicare/Medicaid is six (6) months from the date of the Medicare payment.

Electronic:
If using the ANSI X12 Version 4010, it is not necessary to submit an EOB for a $0 payment or denial. Complete the other payer payment information including payer paid amount, patient liability and reason codes.
Submit to:
HT000004-001

Paper:
An Insurance Payment Report Claim Attachment form must be submitted with the claim regardless of the payment amount. The form and instructions are attached. They should be placed in the General Attachments Section of the Medicaid Provider Manual. A copy will be on-line at http://health.utah.gov/medicaid/ipr.pdf Submit to:
Medicaid Crossovers
PO Box 143106
Salt Lake City, Utah 84114-3106 □

On-Line (Internet) Address for Department of Health, Including Medicaid

The On-Line (Internet) address for Department of Health websites changed to http://health.utah.gov. If you use an earlier address, your browser should redirect you to the new website. To save time, please bookmark the new Medicaid website address: : http://health.utah.gov/medicaid The Internet address in Medicaid documents will be corrected when the document is updated. We apologize for any inconvenience if your browser does not redirect to the new site.